ATTENTION:

Please do not complete this form. This form is only used to give you an idea of the questions we will ask when you apply. It will help you prepare for the interview.

Social Security Administration ☐ TEL TOE 120/145/155 Form Approved OMB No 0950-0012

APPLICATION FOR PARENT'S INSURANCE BENEFITS*

(Do not write in this space)

I apply for all insurance benefits for which I am eligible under Title 11 (Federal Old-Age, Survivors, and Disability Insurance) and Part A of Title XVIII (Health Insurance for the Aged and Disabled) of the Social Security Act, as presently amended.

*This may also be considered an application for survivors benefits under the Railroad Retirement Act and for Veterans Administration payments under Title 38 U.S.C , Veterans Benefits, Chapter 13 (which is, as such, an application for other types of death benefits under Title 38.)

1.	(a) PRINT name of deceased wage earner or self-employed person (herein referred to as the "Deceased.") →	FIRST NAME, MIDDLE INITIAL, LAST NAME	
	(b) Check (X) one for the Deceased. →	☐ Male	☐ Female
	(c) Enter Deceased's Social Security number. →	__ __ __ / __ __ /__ __ __ __	
2.	(a) PRINT your name. →	FIRST NAME, MIDDLE INITIAL, LAST NAME	
	(b) Enter your Social Security number. →	__ __ __ / __ __ /__ __ __ __	
	(c) Enter your name at birth if different from item 2(a). →		
3.	(a) Were you receiving at least one-half of your support from the Deceased at the time the Deceased became disabled under the Social Security law or at the time of death? →	☐ Yes *(If "Yes," answer (b).)*	☐ No *(If "No," go on to item 4.)*
	(b) Have you filed proof of this support with the Social Security Administration? →	☐ Yes	☐ No

PART I -- INFORMATION ABOUT THE DECEASED

4.	Enter date of birth of Deceased. →	MONTH, DAY, YEAR	
5.	(a) Enter date of death. →	MONTH, DAY, YEAR	
	(b) Enter place of death. →	CITY AND STATE	
6.	(a) Did the Deceased ever file an application for Social Security benefits, a period of disability under Social Security, Supplemental Security Income, or hospital or medical insurance under Medicare? →	☐ Yes *(If "Yes," answer (b) and (c).)*	☐ No *(If "No" or "Unknown" go on to item 7.)* ☐ Unknown
	(b) Enter name of person on whose Social Security record other application was filed. →	FIRST NAME, MIDDLE INITIAL, LAST NAME	
	(c) Enter Social Security number of person named in (b), (If "Unknown," so indicate.) →	__ __ __ / __ __ /__ __ __ __	

Answer Item 7 ONLY if the Deceased Died Prior to Age 66 and Within the Past 4 Months.

7.	(a) Was the Deceased unable to work because of a disabling condition at the time of death? →	☐ Yes *(If "Yes," answer (b).)*	☐ No *(If "No," go on to item 8.)*
	(b) Enter date Disability began. →	MONTH, DAY, YEAR	

8.	(a) Was the Deceased in the active military or naval service (including Reserve or National Guard active duty or active duty for training) after September 7, 1939 and before 1968? →	☐ Yes *(If "Yes," answer (b) and (c).)*	☐ No *(If "No," go on to item 9.)*
	(b) Enter dates of service. →	From: (Month, year)	To: (Month, year)
	(c) Have you received, or do you expect to receive, a benefit from any other Federal agency? →	☐ Yes	☐ No

Answer Item 9 ONLY If Death Occurred With the Last 2 Years.

9.	(a) About how much did the Deceased earn from employment and self-employment during the year of death? →	AMOUNT $	☐ Unknown
	(b) About now much did the Deceased earn the year before death? →	AMOUNT $	☐ Unknown
10.	(a) Did the deceased have wages or self-employment income covered under Social Security in all years from 1978 through last year? →	☐ Yes *(If "Yes," skip to item 11.)*	☐ No *(If "No," answer (b).)*
	(b) List the years from 1978 through last year in which the deceased did not have wages or self-employment income covered under Social Security. →		
11.	Check if applicable: ☐ I am not submitting evidence of the deceased's earnings that are not yet on his/her earnings record. I understand that these earnings will be included automatically within 24 months, and any increase in my benefits will be paid with full retroactivity.		

PART II -- INFORMATION ABOUT YOURSELF

12.	(a) Enter your date of birth. →	MONTH, DAY, YEAR	
	(b) Enter name of State or Foreign country where you were born. →		
	If you have already presented, or if you are now presenting, a public or religious record of your birth established before you were age 5, go on to item 13.		
	(c) Was a public record of your birth made before you were age 5? →	☐ Yes	☐ No ☐ Unknown
	(d) Was a religious record of your birth made before you were age 5? →	☐ Yes	☐ No ☐ Unknown
13.	Have you married since the death of the Deceased? →	☐ Yes	☐ No
14.	(a) Have you ever filed an application for Social Security benefits, a period of disability under Social Security, Supplemental Security Income, or hospital or medical insurance under Medicare? →	☐ Yes *(If "Yes," answer (b) and (c).)*	☐ No *(If "No," go on to item 15.)*

	(b) Enter name of person on whose Social Security record you filed other application. →	
	(c) Enter Social Security number of person named in (b). ***(If "Unknown," so indicate.)*** →	__ __ __ / __ __ /__ __ __ __
15.	Were you in the active military or naval service (including Reserve or National Guard active duty or active duty for training) after September 7, 1939 and before 1968? →	☐ Yes ☐ No
16.	Did you, your spouse, or the Deceased work in the railroad industry for 7 years or more? →	☐ Yes ☐ No
17.	(a) **Do you have social security credits (for example, based on work or residence) under another country's social security system?** →	☐ Yes *(If "Yes," answer (b).)* ☐ No *(If "No," go on to item 18.)*
	(b) List the country(ies). →	

Answer Item 18 ONLY if the Deceased, Died Before, This Year.

18.	(a) How much were your total earnings last year? →	$		
	(b) Place an "X" in each block for EACH MONTH of last year in which you did not earn more than *$ _____ in wages, and did not perform substantial services in self-employment. These months are exempt months. If no months were exempt months, place an "X" in "NONE". If all months were exempt months, place an "X" in "ALL". → *Enter the appropriate monthly limit after reading the instructions, "How Your Earnings Affect Your Benefits".	NONE		ALL
		JAN	FEB	MAR
		APR	MAY	JUN
		JUL	AUG	SEPT
		OCT	NOV	DEC
19.	(a) How much do you expect your total earnings to be this year? →	$		
	(b) Place an "X" in each block for EACH MONTH of this year in which you did not earn or will not earn more than *$ _____ in wages, and did not or will not perform substantial services in self-employment. These months are exempt months. If no months are or will be exempt months, place an "X" in "NONE". If all months are or will be exempt months, place an "X" in "ALL". → *Enter the appropriate monthly limit after reading the instructions, "How Your Earnings Affect Your Benefits".	NONE		ALL
		JAN	FEB	MAR
		APR	MAY	JUN
		JUL	AUG	SEPT
		OCT	NOV	DEC

Answer this item ONLY if you are not in the last 4 months of your taxable year (Sept., Oct., Nov., and Dec., if your taxable year is a calendar year).

20.	(a) How much do you expect to earn next year? →	$		
	(b) Place an "X" in each block for EACH MONTH of next year in which you do not expect to earn more than *$_____ in wages, and do not expect to perform substantial services in self-employment. These months will be exempt months. If no months are expected to be exempt months, place an "X" in "NONE". If all months are expected to be exempt months, place an "X" in "ALL". → *Enter the appropriate monthly limit after reading the instructions, "How Your Earnings Affect Your Benefits".	NONE		ALL
		JAN	FEB	MAR
		APR	MAY	JUN
		JUL	AUG	SEPT
		OCT	NOV	DEC
21.	If you use a fiscal year, that is, a taxable year that does not end December 31 (with income tax return due April 15) enter here the month your fiscal year ends. →	MONTH		

The law requires that a report of earnings be filed with SSA within 3 months and 15 days after the end of any taxable year in which you earn more than the annual exempt amount. You may contact SSA to file a report. Otherwise, SSA will use the earnings reported by your employer(s) and your self-employment tax return as the report of earnings required by law and adjust benefits under the earnings test. It is your responsibility to ensure that the information you give concerning your earnings is correct.

I UNDERSTAND THE EARNINGS REPORTING REQUIREMENT AND I AGREE TO PROVIDE EARNINGS INFORMATION WHEN NEEDED TO ENSURE ACCURATE PAYMENT OF BENEFITS.

MEDICARE INFORMATION

If this claim is approved and you are still entitled to benefits at age 65, you will automatically have hospital insurance protection under Medicare at age 65. If you are not also eligible for automatic enrollment in the Supplementary Medical Insurance Plan, this application may be used for voluntary enrollment.

Complete This Item ONLY If You Are Within 3 Months of Age 65 or Older

ENROLLMENT IN MEDICARE'S SUPPLEMENTARY MEDICAL INSURANCE PLAN: The medical insurance benefits plan pays for most of the costs of physicians' and surgeons' services, and related medical services which are not covered by the hospital insurance plan. Coverage under this SUPPLEMENTARY MEDICAL INSURANCE PLAN does not apply to most medical expenses incurred outside the United States. Your Social Security district office will be glad to explain the details of the plan and give you a leaflet which explains what services are covered and how payment is made under the plan.

Once you are enrolled in this plan, you will have to pay a monthly premium to cover part of the cost of your medical insurance protection. The Federal Government contributes an equal amount or more toward the cost of your insurance, Premiums will be deducted from any monthly Social Security, railroad retirement, or civil service benefit checks you receive. If you do not receive such benefits, you will be notified about when, where, and how to pay your premiums, It you are eligible for automatic enrollment, you will be automatically enrolled unless you indicate, by checking the "NO" block below, that you do not want to be enrolled.

22.	DO YOU WANT TO ENROLL IN THE MEDICARE SUPPLEMENTARY MEDICAL INSURANCE PLAN?	☐ Yes ☐ No

Generally, remarriage will end your entitlement to parent's benefits. There are certain exceptions which are explained in the informational booklet which you will receive. You must report it you remarry even if you believe an exception applies. We will advise you whether additional evidence is needed and how your benefits may be affected.

I AGREE TO PROMPTLY NOTIFY the Social Security Administration if I REMARRY or it I am incarcerated for conviction of a felony, and to PROMPTLY RETURN ANY BENEFIT CHECK I receive for the month I remarry or am incarcerated, and for any later month.

REMARKS (You may use this space for any explanations. If you need more space, attach a separate sheet.)

I know that anyone who makes or causes to be made a false statement or representation of material fact In an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment or both. I affirm that all Information I have given In this document is true.

SIGNATURE OF APPLICANT

Date **(Month, day, year)**

Signature **(First Name, Middle Initial, Last Name) (Write in ink)**

SIGN HERE ▶

Telephone number(s) at which you may be contacted during the day

(AREA CODE)

FOR OFFICIAL USE ONLY

Direct Deposit Payment Address *(Financial Institution)*

Routing Transit Number	C/S	Depositor Account Number	☐ No Account ☐ Direct Deposit Refused

Applicant's Mailing Address **(Number and street, Apt No., P.O. Box, or Rural Route) (Enter Residence Address in "Remarks," if different.)**

City and State	ZIP Code	County **(if any)** in which you now live

Witnesses are required ONLY if this application has been signed by mark (X) above. If signed by mark (X), two witnesses who know the applicant must sign below, giving their full addresses. Also, print the applicant's name in the Signature block.

1. Signature of Witness	2. Signature of Witness
Address ***(Number and Street, City, State and ZIP Code)***	Address **(Number and Street, City, State and ZIP Code)**

COLLECTION AND USE OF INFORMATION FROM YOUR APPLICATION
PRIVACY ACT NOTICE/PAPERWORK ACT NOTICE

I. The Social Security Administration is authorized to collect the information on this form under sections 202(h), 205(a), and 1872 of the Social Security Act, as amended (42 U.S.C. 402(h), 405(a), and 1395ii).

II. While it is voluntary, except in the circumstances explained below, for you to furnish the information on this form to Social Security, no benefits may be paid unless an application has been received by a Social Security office. Your response is mandatory where the refusal to disclose certain information affecting your right to payment would reflect a fraudulent intent to secure benefits not authorized by the Social Security Act.

III. The information on this form is needed to enable Social Security to determine if you and your dependents are entitled to insurance coverage and/or monthly benefits.

IV. Failure to provide all or part of this information could prevent an accurate and timely decision on your claim, and could result in the loss of some benefits or insurance coverage.

V. Although the information you furnish on this form is almost never used for any other purpose than stated in the foregoing, there is a possibility that for the administration of the Social Security programs or for the administration of programs requiring coordination with the Social Security Administration, information may be disclosed to another person or to another governmental agency as follows:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;

2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the General Accounting Office and the Veterans Administration);

3. To facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Social Security programs (e.g , to the Bureau of the Census and private concerns under contract to Social Security)

VI. COMPUTER MATCHING: We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

The law requires that a report of earnings be filed with SSA within 3 months and 15 days after the end of any taxable year in which you earn more than the annual exempt amount. You may contact SSA to file a report. Otherwise, SSA will use the earnings reported by your employer(s) and your self-employment tax return (if applicable) as the report of earnings required by law and adjust benefits under the earnings test. It is your responsibility to ensure that the information you give concerning your earnings is correct.

Generally, remarriage will end your entitlement to parent's benefits. There are certain exceptions which are explained in the informational booklet which you will receive. You must report if you remarry even if you believe an exception applies. We will advise you whether additional evidence is needed and how your benefits may be affected.

The **Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 15 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form.

RECEIPT FOR YOUR CLAIM FOR SOCIAL SECURITY PARENT'S INSURANCE BENEFITS

TELEPHONE NUMBER(S) TO CALL IF YOU HAVE A QUESTION OR SOMETHING TO REPORT	**BEFORE** YOU RECEIVE A NOTICE OF AWARD __ __ __ (AREA CODE)	SSA OFFICE	DATE CLAIM RECEIVED
	AFTER YOU RECEIVE A NOTICE OF AWARD __ __ __ (AREA CODE)		

Your application for Social Security benefits has been received and will be processed as quickly as possible.

You should hear from us within _____ days after you have given us all the information we requested. Some claims may take longer if additional information is needed.

In the meantime, if you have a change of address, or if there is some other change that may affect your claim, you or someone for you, should report the change. The changes to be reported are listed below.

Always give us your claim number when writing or telephoning about your claim.

If you have any questions about your claim, we will be glad to help you.

CLAIMANT	SOCIAL SECURITY CLAIM NUMBER

DECEASED'S NAME *(If surname differs from name of claimant)*

CHANGES TO BE REPORTED AND HOW TO REPORT

Failure to report may result in overpayments that must be repaid and in possible monetary penalties.

- You change your mailing address for checks or residence. *(To avoid delay in receipt of checks you should ALSO file a regular change of address notice with your post office.)*
- You go outside the U.S.A. for 30 consecutive days or longer.
- Any beneficiary dies or becomes unable to handle benefits.
- Work Changes - On your application you told us you expect total earnings for _____ to be $_____ .

  You ☐ (are) ☐ (are not) earning wages of more than $_____ a month.

  You ☐ (are) ☐ (are not) self-employed rendering substantial services in your trade or business.

  *(Report **AT ONCE** if this work pattern changes)*
- Custody Change - Report if a person for whom your a filing, or who is in your care dies, leaves your care or custody, changes address.
- Change of Marital Status - Report if you remarry.
- You are confined to jail, prison, penal institution or correctional facility for conviction of a crime or you are confined to a public institution by court order in connection with a crime.

HOW TO REPORT

You can make you reports by telephone, mail or in person, whichever you prefer.

WHEN A CHANGE OCCURS AFTER YOU RECEIVE A NOTICE OF AWARD, YOU SHOULD REPORT BY CALLING THE APPROPRIATE TELEPHONE NUMBER SHOWN NEAR THE TOP OF THIS PAGE.